Basic (Level IV) Trauma Facility Criteria Checklist

Basic (Level IV) Trauma Facility - provides resuscitation, stabilization, and assessment of injury victims and either provides treatment or arranges for appropriate transfer to a higher level designated trauma facility; provides ongoing educational opportunities in trauma related topics for health care professionals and the public; and implements targeted injury prevention programs.

Basic (Level IV) Essential Criteria	Criteria	Hospital		Surveyor		Comments
		Met	Not Met	Met	Not Met	
A. TRAUMA PROGRAM						
1. An identified Trauma Medical Director (TMD) who: • is currently credentialed in Advanced Trauma Life Support (ATLS) or an equivalent course approved by the Department of State Health Services (DSHS). • is charged with overall management of trauma services provided by the hospital. • shall have the authority and responsibility for the clinical oversight of the trauma program. This is accomplished through mechanisms that may include: credentialing of medical staff who provide trauma care; providing trauma care; developing treatment protocols; cooperating with the nursing administration to support the nursing needs of the trauma patients; coordinating the performance improvement (PI) peer review; and correcting deficiencies in trauma care. a. There shall be a defined job description and organizational chart delineating the TMD's role and responsibilities. b. The TMD shall be credentialed by the hospital to participate in the resuscitation and treatment of trauma patients using criteria to include such things as board-certification/board-eligibility, trauma continuing medical education, compliance with trauma protocols, and participation in the trauma PI program. c. The TMD shall participate in a leadership role in the hospital, community, and emergency management (disaster) response committee. d. The TMD should participate in the development of the regional trauma system plan.	**E**					

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2. An identified Trauma Nurse Coordinator/Trauma Program Manager (TNC/TPM) who: • who is a registered nurse • has successfully completed and is current in the Trauma Nurse Core Course (TNCC) or Advanced Trauma Course for Nurses (ATCN) or a DSHS-approved equivalent. • has successfully completed and is current in a nationally recognized pediatric advanced life support course ((e.g. Pediatric Advanced Life Support (PALS) or the Emergency Nurse Pediatric Course (ENPC)). • has the authority and responsibility to monitor trauma patient care from ED admission through operative intervention(s), ICU care, stabilization, rehabilitation care, and discharge, including the trauma PI program. a. There shall be a defined job description and organizational chart delineating the TNC/TPM's role and responsibilities. b. The TNC/TPM shall participate in a leadership role in the hospital, community, and regional emergency management (disaster) response committee. c. Trauma programs should have a minimum of .8 FTE dedicated to the TNC/TPM position. d. The TNC/TPM should complete a course designed for his/her role which provides essential information on the structure, process, organization and administrative responsibilities of a PI program to include a trauma outcomes and performance improvement course ((e.g. Trauma Outcomes Performance Improvement Course (TOPIC) or Trauma Coordinators Core Course (TCCC)).	**E**					
3. An identified Trauma Registrar who has appropriate training ((e.g. the Association for the Advancement of Automotive	**E**					

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Medicine (AAAM) course, American Trauma Society (ATS) Trauma Registrar Course)) in injury severity scaling. Typically, one full-time equivalent (FTE) employee dedicated to the registry shall be required to process approximately 500 patients annually.						
4. Written protocols, developed with approval by the hospital's medical staff for: a. Trauma team activation b. Identification of trauma team responsibilities during a resuscitation c. Resuscitation and Treatment of trauma patients d. Triage, admission and transfer of trauma patients	**E**					
B. PHYSICIAN SERVICES						
1. **Emergency Medicine** - this requirement may be fulfilled by a physician credentialed by the hospital to provide emergency medical services Any emergency physician who is providing trauma coverage shall be credentialed by the TMD to participate in the resuscitation and treatment of trauma patients of all ages to include requirements such as current board certification/eligibility**,** an average of 9 hours of trauma-related continuing medical education per year**,** compliance with trauma protocols, and participation in the trauma PI program. An Emergency Medicine board-certified physician who is providing trauma coverage shall have successfully completed an ATLS Student Course or a DSHS-approved ATLS equivalent course. Current ATLS verification is required for all physicians who work in the ED and are not board certified in Emergency Medicine.	**E**					

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The emergency physician representative to the multidisciplinary committee that provides trauma coverage to the facility shall attend 50% or greater of multidisciplinary and peer review trauma committee meetings.						
2. **Radiology**	**D**					
3. **Anesthesiology**-requirements may be fulfilled by a member of the anesthesia care team credentialed in assessing emergent situations in trauma patients and providing any indicated treatment.	**D**					
4. **Primary Care Physician**-The patient's primary care physician should be notified at an appropriate time.	**D**					
C. NURSING SERVICES (for all Critical Care and Patient Care Areas)						
1. All nurses caring for trauma patients throughout the continuum of care have ongoing documented knowledge and skills in trauma nursing for patients of all ages to include trauma specific orientation, annual clinical competencies, and continuing education.	**E**					
2. Written standards on nursing care for trauma patients for all units (i.e. ED, ICU, OR, PACU, general wards) in the trauma facility shall be implemented.	**E**					
3. A written plan, developed by the hospital, for acquisition of additional staff on a 24 hour basis to support units with increased patient acuity, multiple emergency procedures and admissions (i.e. written disaster plans).	**E**					
4. 50% of nursing caring for trauma patients should be certified in their area of specialty (e.g. CEN, CCRN, CNRN, etc.).	**D**					
D. EMERGENCY DEPARTMENT						
1. The published physician on-call schedule must be available in the ED.	**E**					
2. Physician with special competence in the care of critically injured patients, who is designated member of the trauma team and who is on-call (if not in-house 24/7) and promptly available within 30 minutes of request from inside or outside	**E**					

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the hospital.* **Neither a hospital's telemedical capabilities nor the physical presence of physician assistants (PAs) or clinical nurse specialists/nurse practitioners (CNSs/NPs) shall satisfy this requirement. Additionally, PAs/NPs and telemedicine-support physicians who participate in the care of major/severe trauma patients shall be credentialed by the hospital to participate in the resuscitation and treatment of said trauma patients, to include requirements such as board certification/eligibility, an average of 9 hours of trauma-related continuing medical education per year, compliance with trauma protocols, and participation in the trauma PI program.*						
3. The physician on duty or on-call to the emergency department (ED) shall be activated on EMS communication with the ED or after a primary assessment of patients who arrive to the ED by private vehicle for the major or severe trauma patient. Response time shall not exceed thirty minutes from notification (this criterion shall be monitored in the trauma PI program.)	**E**					
4. A minimum of one and preferably two registered nurses who have trauma nursing training shall participate in initial major trauma resuscitations.	**E**					
5. Nurse staffing in initial resuscitation area is based on patient acuity and trauma team composition based on historical census and acuity data.	**E**					
6. At least one member of the registered nursing staff responding to the trauma team activation for a major or severe trauma resuscitation has successfully completed and holds current credentials in an advanced cardiac life support course (e.g. ACLS or hospital equivalent), a nationally recognized pediatric advanced life support course (e.g. PALS or ENPC) and TNCC or ATCN or a DSHS-approved equivalent.	**E**					
7. 100% of nursing staff have successfully completed and hold current credentials in an advanced cardiac life support course (e.g. ACLS or hospital equivalent), a nationally recognized pediatric advanced life support course (e.g.	**E**					

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PALS or ENPC) and TNCC or ATCN or a DSHS-approved equivalent, within 18 months of date of employment in the ED or date of designation.						
8. Nursing documentation for trauma patients is systematic and meets the trauma registry guidelines.	**E**					
9. Two-way communication with all pre-hospital emergency medical services vehicles.	**E**					
10. Equipment and services for the evaluation and resuscitation of, and to provide life support for, critically or seriously injured patients of all ages shall include but not be limited to:	**E**					
a. Airway control and ventilation equipment including laryngoscope and endotracheal tubes of all sizes, bag-valve-mask devices (BVMs), pocket masks, and oxygen	**E**					
b. Mechanical ventilator	**E**					
c. Pulse oximetry	**E**					
d. Suction devices	**E**					
e. Electrocardiograph-oscilloscope-defibrillator	**E**					
f. Supraglottic airway management device (e.g. LMA)	**D**					
g. Apparatus to establish central venous pressure monitoring equipment.	**D**					
h. All standard intravenous fluids and administration devices, including large-bore intravenous catheters and a rapid infuser system.	**E**					
i. Sterile surgical sets for procedures standard for the emergency room such as thoracostomy, venous cutdown, central line insertion, thoracotomy, airway control/cricothyrotomy, etc.	**E**					
j. Drugs and supplies necessary for emergency care.	**E**					
k. Cervical spine stabilization device.	**E**					
l. Length-based body weight & tracheal tube size evaluation system (such as Broselow tape) and resuscitation medication and equipment that are dose-appropriate for all ages.	**E**					

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m. Long bone stabilization device. n. Pelvic stabilization device. o. Thermal control equipment for patients and a rapid warming device for blood and fluids. p. Non-invasive continuous blood pressure monitoring devices. q. Qualitative end tidal CO2 monitoring.	**E** **E** **E** **E** **E**					
11. X-ray capability.	**E**					
E. CLINICAL LABORATORY SERVICE (available 24 hours per day)						
1. Call-back process for trauma activations available within 30 minutes. This system shall be continuously monitored in the trauma PI program.	**E**					
2. Standard analyses of blood, urine, and other body fluids, including micro-sampling.	**E**					
3. Blood typing and cross-matching.	**D**					
4. Capability for immediate release of blood for a transfusion and a protocol to obtain additional blood supply.	**E**					
5. Coagulation studies	**E**					
6. Blood gases and pH determinations.	**E**					
7. Drug and alcohol screening-toxicology screens need not be immediately available but are desirable (if available, results should be included in all trauma PI reviews).	**D**					
F. RADIOLOGICAL CAPABILITIES (available 24 hours per day)						
1. Call-back process for trauma activations available within 30 minutes. This system shall be continuously monitored in the trauma PI program.	**E**					
2. 24-hour coverage by in-house technician.	**D**					
3. Computerized tomography	**D**					

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G. PERFORMANCE IMPROVEMENT						
1. Track record. On Initial Designation: a facility must have completed at least six months of audits on all qualifying trauma records with evidence of "loop closure" on identified issues. Compliance with internal trauma policies must be evident. On Re-designation: a facility must show continuous PI activities throughout its designation and a rolling current three year period must be available for review at all times.	**E**					
2. Minimum inclusion criteria: All trauma team activations (including those discharged from the ED), all trauma deaths or dead on arrivals (DOAs), all major and severe trauma admissions; transfers-in and transfers-out; and readmissions within 48 hours after discharge	**E**					
3. An organized trauma PI program established by the hospital, to include a pediatric-specific component and trauma audit filters (see "Basic Trauma Facility Audit Filters" list.)	**E**					
a. Audit of trauma charts for appropriateness and quality of care.	**E**					
b. Documented evidence of identification of all deviations from trauma standards of care, with in-depth critical review	**E**					
c. Documentation of actions taken to address all identified issues	**E**					
d. Documented evidence of participation by the TMD.	**E**					
e. Morbidity and mortality review including decisions by the TMD as to whether or not standard of care was met.	**E**					
f. Documented resolutions "loop closure" of all identified issues to prevent future recurrences.	**E**					
g. Special audit for all trauma deaths and other specified cases, including complications, utilizing age-specific criteria.	**E**					
h. Multidisciplinary hospital trauma PI committee structure in place	**E**					

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4. Multidisciplinary trauma conferences, continuing education and problem solving to include documented nursing and pre-hospital participation	**D**					
5. Feedback regarding major/severe trauma patient transfers-out from the ED and in-patient units shall be obtained from receiving facilities.	**E**					
6. Trauma registry - data shall be forwarded to the state trauma registry on at least a quarterly basis.	**E**					
7. Documentation of severity of injury (by Glasgow Comma Scale, revised trauma score, age, injury severity score) and outcome (survival, length of stay, ICU length of stay) with monthly review of statistics.	**E**					
8. Participation with the regional advisory council's (RAC) PI program, including adherence to regional protocols, review of pre-hospital trauma care, submitting data to the RAC as requested including such things as summaries of transfer denials and transfers to hospitals outside of the RAC.	**E**					
9. Times of and reasons for diversion must be documented and reviewed by the trauma PI program.	**E**					
H. REGIONAL TRAUMA SYSTEM						
1. Must participate in the regional trauma system per RAC	**E**					
I. TRANSFERS						
1. A process to expedite the transfer of major and severe trauma patients to include such things as written protocols, written transfer agreements, and a regional trauma system transfer plan for patients needing higher level of care or specialty services (i.e. surgery, burns, etc.)	**E**					
2. A system for establishing an appropriate landing zone in close proximity to the hospital (if rotor wing services are available.)	**E**					

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J. PUBLIC EDUCATION/INJURY PREVENTION						
1. A public education program to address the major injury problems within the hospital's service area. Documented participation in a RAC injury prevention program is acceptable.	**E**					
2. Coordination and/or participation in community/RAC injury prevention activities.	**E**					
K. TRAINING PROGRAMS						
1. Formal programs in trauma continuing education provided by hospital for staff based on needs identified from the trauma PI program for:	**E**					
a. Staff physicians	**E**					
b. Nurses	**E**					
c. Allied health personnel, including mid-level providers such as physician assistants and nurse practitioners.	**E**					